

Monique Gaboury L.Ac., CST
5492 Myrtle Ave, Suite 200
Freeland, WA 98249
360-672-1506

Patient Health History

Name _____ Date _____

Address _____

Phone _____ Email _____

Preferred method of communication- voicemail, text, email (circle as many as apply).

Date of Birth _____ Emergency Contact _____

Emergency Contact # _____ Relationship _____

Family Physician _____ Phone _____

Date of Last Physical _____

With whom do you live? _____

What brings you the greatest joy? _____

What is most stressful or dissatisfying in your life currently? _____

Have you been treated with East Asian Medicine/Acupuncture before? If so, for what issue? _____

What are you seeking care for at this time? _____

Date of onset _____ Is it improving or worsening? _____

Have you been diagnosed for this issue? _____

What treatments have you tried for this issue, and what were their outcomes?

Illnesses (current and past) _____

Surgeries (include date) _____

Trauma (physical or emotional) _____

History of infectious disease (current or past) _____

Medications (including herbs, supplements, over the counter, and prescriptions) and for what they are being taken? _____

Describe a typical meal for: Breakfast _____

Lunch _____

Supper _____

Snacks _____

Fluid intake per day (what type and how much)? _____

Exercise (what type)? _____

How many hours per night of sleep? _____ Do you awake rested? _____

What nourishes your spirit? _____

Occupation _____ Occupational hazards _____

What type of support system do you have? _____

Nicotine, alcohol, caffeine, recreational drug use (include how much and how often)?

Family Medical History

Alcoholism _____	Cancer _____	High Cholesterol _____
Asthma _____	Depression _____	Mental Illness _____
Allergies _____	Diabetes _____	Stroke _____
Autoimmune _____	Heart Disease _____	Other _____
Arthritis _____	High Blood Pressure _____	

General Review of Systems (Put a P for Past or C for Current Beside Checked Boxes)

<input type="checkbox"/> Chills	<input type="checkbox"/> Strong Thirst	<input type="checkbox"/> Bruise Easily
<input type="checkbox"/> Fever	<input type="checkbox"/> Sudden Energy Drop	<input type="checkbox"/> Bleed Easily
<input type="checkbox"/> Night Sweats	<input type="checkbox"/> Local Weakness	<input type="checkbox"/> Weight Loss
<input type="checkbox"/> Sweat Easily	<input type="checkbox"/> Poor Sleep	<input type="checkbox"/> Weight Gain
<input type="checkbox"/> Puffiness/Swelling	<input type="checkbox"/> Poor Balance	<input type="checkbox"/> Fatigue
<input type="checkbox"/> Appetite Changes	<input type="checkbox"/> Poor Appetite	<input type="checkbox"/> Tremors
<input type="checkbox"/> Peculiar Cravings		

Skin and Hair

<input type="checkbox"/> Rashes <input type="checkbox"/> Itching <input type="checkbox"/> Skin Ulcers <input type="checkbox"/> Hives	<input type="checkbox"/> Eczema <input type="checkbox"/> Psoriasis <input type="checkbox"/> Acne <input type="checkbox"/> Dandruff	<input type="checkbox"/> Hair Loss <input type="checkbox"/> Fungal Infections <input type="checkbox"/> Moles <input type="checkbox"/> Other
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Head, Eyes, Ears, Nose, Throat

<input type="checkbox"/> Headaches <input type="checkbox"/> Migraines <input type="checkbox"/> Dizziness <input type="checkbox"/> Concussion <input type="checkbox"/> Poor Vision <input type="checkbox"/> Floaters <input type="checkbox"/> Cataracts <input type="checkbox"/> Dry Eyes <input type="checkbox"/> Blurred Vision	<input type="checkbox"/> Night Blindness <input type="checkbox"/> Color Blind <input type="checkbox"/> Blind Spots <input type="checkbox"/> Eye Discharge <input type="checkbox"/> Poor Hearing <input type="checkbox"/> Ringing in Ears <input type="checkbox"/> Ear Ache <input type="checkbox"/> Ear Discharge <input type="checkbox"/> Sinus Issues	<input type="checkbox"/> Nosebleeds <input type="checkbox"/> Taste/Smell Issues <input type="checkbox"/> Teeth Grinding <input type="checkbox"/> Jaw Pain <input type="checkbox"/> Recurring Sore Throat <input type="checkbox"/> Lump in Throat <input type="checkbox"/> Tooth/Gum Issues <input type="checkbox"/> Tongue/Mouth Ulcers
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Cardiovascular

<input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Low Blood Pressure <input type="checkbox"/> Cold Hands/Feet <input type="checkbox"/> Swelling of Hands/Feet <input type="checkbox"/> Varicose Veins	<input type="checkbox"/> Chest Pain <input type="checkbox"/> Palpitations <input type="checkbox"/> Irregular Heartbeat <input type="checkbox"/> Heart Attack <input type="checkbox"/> Heart Murmur	<input type="checkbox"/> TIA/Stroke <input type="checkbox"/> Dizziness <input type="checkbox"/> Fainting <input type="checkbox"/> Anemia <input type="checkbox"/> Tingling Hands or Feet
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Respiratory

<input type="checkbox"/> Asthma <input type="checkbox"/> Cough <input type="checkbox"/> Phlegm	<input type="checkbox"/> Painful Breathing <input type="checkbox"/> Difficulty Breathing <input type="checkbox"/> Coughing Blood	<input type="checkbox"/> Easily Winded <input type="checkbox"/> Bronchitis <input type="checkbox"/> Pneumonia
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Gastrointestinal

<input type="checkbox"/> Bad Breath <input type="checkbox"/> Acid Regurgitation <input type="checkbox"/> Nausea/Vomiting <input type="checkbox"/> Indigestion <input type="checkbox"/> Hiccups <input type="checkbox"/> Belching <input type="checkbox"/> Ulcers <input type="checkbox"/> Bloating After Meals	<input type="checkbox"/> Increased Appetite <input type="checkbox"/> Decreased Appetite <input type="checkbox"/> Constipation <input type="checkbox"/> Gas <input type="checkbox"/> Diarrhea <input type="checkbox"/> Loose Stools <input type="checkbox"/> Blood in Stools <input type="checkbox"/> Chronic Laxative Use	<input type="checkbox"/> Polyps <input type="checkbox"/> Irritable Bowel <input type="checkbox"/> Inflammatory Bowel <input type="checkbox"/> Leaky Gut <input type="checkbox"/> Gallstones or Gallbladder Disease <input type="checkbox"/> Hemorrhoids <input type="checkbox"/> Abdominal Pain
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Urinary

<input type="checkbox"/> Painful Urination <input type="checkbox"/> Urgency to Urinate <input type="checkbox"/> Increase/Decrease Output	<input type="checkbox"/> Cloudy Urine <input type="checkbox"/> Unable to Hold Urine <input type="checkbox"/> Bloody Urine	<input type="checkbox"/> Frequent Urination <input type="checkbox"/> Frequent Urination at Night <input type="checkbox"/> Kidney Stones or Disease
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Gynecology

<input type="checkbox"/> PMS <input type="checkbox"/> Irregular Periods <input type="checkbox"/> Painful Periods <input type="checkbox"/> Heavy Flow <input type="checkbox"/> Light Flow <input type="checkbox"/> Color of Blood _____ <input type="checkbox"/> Spotting	<input type="checkbox"/> Clotting <input type="checkbox"/> Uterine Fibroids <input type="checkbox"/> Endometriosis <input type="checkbox"/> Vaginal Discharge <input type="checkbox"/> Vaginal Sores <input type="checkbox"/> Vaginal Infections <input type="checkbox"/> STD's <input type="checkbox"/> Difficulty Conceiving	<input type="checkbox"/> # of Pregnancies <input type="checkbox"/> # of Births <input type="checkbox"/> Date of Menopause <input type="checkbox"/> Breast Lumps <input type="checkbox"/> Nipple discharge <input type="checkbox"/> Ovarian Cysts <input type="checkbox"/> Hysterectomy <input type="checkbox"/> Increase/Decrease Sexual Energy
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Men

<input type="checkbox"/> BPH <input type="checkbox"/> Prostate Cancer <input type="checkbox"/> Testicular Cancer	<input type="checkbox"/> STD's <input type="checkbox"/> Sexual Difficulties <input type="checkbox"/> Increase/Decrease Sexual Energy	<input type="checkbox"/> Difficulty Conceiving <input type="checkbox"/> Penile Discharge
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Musculoskeletal

<input type="checkbox"/> Arthritis <input type="checkbox"/> Muscle Spasms <input type="checkbox"/> Pain When Weather Changes <input type="checkbox"/> Muscle Cramps	<input type="checkbox"/> Muscle Weakness <input type="checkbox"/> Scoliosis <input type="checkbox"/> Pain Better with Activity <input type="checkbox"/> Pain Better with Rest	<input type="checkbox"/> Pain Upon Awakening <input type="checkbox"/> Major Musculoskeletal Injuries/Problems _____ _____
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Endocrine

<input type="checkbox"/> Hypothyroid <input type="checkbox"/> Hyperthyroid	<input type="checkbox"/> Diabetes <input type="checkbox"/> Hypoglycemia	<input type="checkbox"/> Adrenal Problems <input type="checkbox"/> Other _____
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Neuropsychological

<input type="checkbox"/> Seizures <input type="checkbox"/> Tremors <input type="checkbox"/> Tics <input type="checkbox"/> Numbness <input type="checkbox"/> Paralysis <input type="checkbox"/> Poor Memory <input type="checkbox"/> Irritability/Frustration	<input type="checkbox"/> Sadness/Lack of Joy <input type="checkbox"/> Grief <input type="checkbox"/> Cyclic Thinking/Worry <input type="checkbox"/> Depression <input type="checkbox"/> Anxiety <input type="checkbox"/> Suicide Attempt <input type="checkbox"/> Other _____	<input type="checkbox"/> Sleep Disorders <input type="checkbox"/> Mood Swings <input type="checkbox"/> Vertigo <input type="checkbox"/> Lack of Balance <input type="checkbox"/> Lack of Coordination <input type="checkbox"/> Concussion <input type="checkbox"/> Substance Abuse <input type="checkbox"/> Abuse Survivor
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Thank you for your time in filling out your health history. This information is completely confidential and is used as a part of your East Asian Medicine diagnosis and treatment plan.

